MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, April 13, 2001
9:02 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
AUTRY O.V. DeBUSK
GLENN M. HACKBARTH
FLOYD D. LOOP, M.D.
ALAN R. NELSON, M.D.
JANET G. NEWPORT
CAROL RAPHAEL
ROBERT D. REISCHAUER, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM
Bringing Medicare+Choice to rural America
(David Glass, Scott Harrison)

MR. GLASS: Good morning. Now for a totally different topic. This is bringing Medicare+Choice to rural America or not. There are no recommendations in this chapter, and I think we had substantial agreement on the paper from the last meeting, but we want to get the commissioners reaction to the latest draft to make sure that we reflect the Commission's position clearly. I'm going to very briefly run through the main points in the paper.

I'll start with the March recommendation on M+C just so we get that context. In March we said, make M+C payments substantially equal to risk-adjusted fee-for-service payments. This implies that this would prevent market distortion and would imply there are no more floor payments.

We also wanted to investigate sources of fee-for-service variation. It's appearing the use rates may not be a source of wide variation urban to rural but rather in specific local markets. Figuring out what variation there is might suggest changes in payment policies for fee-for-service and M+C that would allow some new options that we haven't considered yet.

Finally, we recommended to enlarge payment areas to produce reliable estimates.

The problem definition. Again, Congress looked around their constituents and they saw that urban had lots of Medicare managed care plans accompanied by extra benefits, and they didn't have

those in rural areas and this was perceived as an inequity in benefits. Congress' solution was bringing M+C plans to rural areas and assumed that they would bring along those healthy benefits with them. But in fact few M+C managed care plans have moved to rural areas, few extra benefits have shown up, and there's been very little enrollment in rural areas.

We suggested that one of the problems, the basic problem is what the markets are like. Market reality is that many rural areas are not conducive to managed care. It's difficult to form networks and negotiate discounts because there are very few providers. Population is sparse. It's difficult to spread the fixed cost and to cover risk. And there's limited opportunity for efficiency gains.

As we say, there's little evidence of entry or interest by managed care plans in moving into rural areas is the bottom line.

We looked at a few other options. Private fee-for-service is an option that's actually happening. The same providers, payments, no management of care, so there's not any scope for efficiency gains. There are additional expenses for the plan: marketing and administration. There are additional expenses for Medicare because of the floors. And as of right now, under the current plan there are additional premiums for beneficiaries. So it seems to be a pretty expensive way to get not much in the way of extra benefits.

DR. WILENSKY: I think we're all fearful of that, but it strikes me that we ought to wait to see how they share the bounty before we make that kind of a conclusion.

MR. GLASS: That was one of the recommendations from the March report was to see where they go.

DR. ROWE: What's the experience, David, so far?

DR. WILENSKY: We don't have any.

DR. ROWE: In terms of the private fee-for-service, in terms of volume?

MR. GLASS: Scott, where are we, about 10,000, 20,000 now?

DR. HARRISON: 13,000.

MR. GLASS: 13,000 enrolled so far across the country.

MS. NEWPORT: And they've been enrolling since September of last year?

DR. REISCHAUER: But to the extent that there is a bounty now, they haven't shared it at all. As a matter of fact, they've taken more money out of the pockets of Medicare beneficiaries to get what the fee-for-service plan --

MR. GLASS: Yes, currently there's a $65 a month premium.

DR. ROWE: Because there's a premium. But they're not getting any benefits for that premium?

DR. WILENSKY: No, they are. But the question is what?

MR. GLASS: There are different cost sharing provisions primarily. And there's some coverage for like when you're out of the country benefits. But then again there's also a 30 percent coinsurance on home health, for instance.

DR. ROWE: There's some benefits so when these poor rural, frail elderly Medicare beneficiaries are traveling to Rome, they're covered under it.

[Laughter.]

DR. ROWE: What was the expected enrollment by now? There must have been a projection as to what was going to happen. Do we know, Scott? Was there a guess? Is this much lower than expected, about what was expected?

DR. HARRISON: In conversations with the company, I don't think they wanted to be that aggressive to start with. I think they wanted to go build slowly, so I suspect they're probably about where they want to be right now.

DR. ROWE: And all the beneficiaries are in one company?

DR. HARRISON: Right now, yes.

DR. WILENSKY: It's actually been astounding -- this seems like such a good deal for the companies -- as to why this hasn't been happening, other than perhaps slow approval by HCFA now.

DR. ROWE: I think in the analyses that are being done in the companies themselves it sounds like it's a less good deal than --

DR. WILENSKY: No, we're not talking about the M+C in the rural area. We're talking now about private fee-for-service where you don't --

DR. ROWE: No, I understand.

DR. WILENSKY: -- you don't have the need to give back all the additional income as benefits. I guess the answer is, apparently not, because they haven't shown up.

DR. ROWE: Not so far.

MR. GLASS: There is apparently another plan that has now applied, another private fee-for-service plan.

DR. WILENSKY: We would have thought there would have been a

rush on early on, and it did not happen.

MS. NEWPORT: I would suggest, respectfully, that right now the phrase, widely available, in reference to private fee-for-service is somewhat an overstatement. I think the inference in the report -- and the concerns are grounded, but I think for a plan that's still got 1 million members, 13,000 to 14,000 isn't exactly a bullet at this point.

I think the issue for plans in looking at this, established traditional M+C Medicare risk plans is finding a line of sight to what's going to happen on Medicare reform, a line of sight on what's going to happen on regulatory simplification, before you start building maybe a not-existing infrastructure to do basically a type of claims processing in rural areas. I think those issues interfere in terms of the structural base that a traditional M+C plan would have, inasmuch as we've got three years of tradition on some of this stuff.

So I think that it's early days, but if you go back to pre-BBA when HCFA had a queue of 60 to 75 applications, and now the queue is six to seven applications, then I think the problem is broader. I think this registers as something to watch with some level of interest in terms of, is this an efficient way to go about this? Will the consumer response eventually -- because it's just started up -- plateau, decline? Med supp comes in or looks better?

I think that there's all sorts of variables that need to be looked at, including maybe a pretty efficient broker, a network that's selling this well. It may not be at the end of the day

very good, but I think there's a lot of things. I just think that it's early. It's not something that overall you see any entry into M+C, much less this.

I just caution that we watch this prudently, but I'm not sure that it's something at the end of the day with Medicare reform coming down the line that will be meaningful or not. I don't know how to draw a conclusion. I just know that there's not a lot of interest in doing this yet.

DR. ROWE: This is, I think, an interesting issue for us to discuss in this context. What I'm hearing from Janet, and maybe elsewhere, is a kind of lack of trust. Yes, it appears it would be a good opportunity, but they killed us on this other thing; what are they going to do here? We'll get going, then they'll crash the budget until we're in crisis. Then they'll say, oh, we cut too much. You're in crisis, we'll have to give you something back. But by then we would have had to pull out of the market.

It's that kind of concern about Medicare as a partner, I guess, that is limiting people's attraction to this. I don't know. Do you know?

MS. ROSENBLATT: I don't know why we haven't looked at it. I don't even know if we have looked at it. But I was going to comment on this because I think the text is extremely negative about these plans and led me to ask the question, what did people who allowed this to exist, who suggested let's have private fee-for-service plans, what was the goal of having it? I know it's too early to measure if we're --

DR. HARRISON: It's not what you'd expect. The original

proponents were actually concerned that the budget was being cut on Medicare too severely and people would have trouble -- they were afraid basically that elderly would be euthanized. This was an ideological plot. So the idea was that you would be able to join a network and actually pay physicians more to make sure you got the care you needed.

DR. WILENSKY: But it's a problem, a particular problem because of the floor issue. Otherwise what you can say is, if a company is able to convince somebody they should pay a premium to get very little in return, then there may be some marketing questions about why seniors think that this is a good idea, except maybe if it's to get access to a pool of physicians who don't participate in Medicare. There are some physicians who don't participate in Medicare. It's not a big problem as best as we can tell, but there clearly are some physicians.

This was a way to allow people to get around some of the existing Medicare reimbursements in a way that was consistent with Medicare law.

It becomes much more costly because of the floor counties, which now guarantee very large differential in some parts of the country if the senior chooses of plan of any sort that qualifies for floor county reimbursement as opposed to staying in traditional Medicare, where at the extremes you have these very wide bands of differences.

So now the question could well be, as long as the senior gets some benefit, even if it's a 90/10 split between the plan and the senior, it still may make sense for seniors in terms of

they'll be better off, but it is a very high price to pay for getting a little additional benefit to seniors.

So the issue of whether or not private fee-for-service plans ought to be allowed, if they were attractive to seniors, if you have the government paying the same amount irrespective of what plans people take, I think is not a big deal. I was not concerned about that at that level. I think people ought to be able to buy what the rest of think is a not very good plan if they choose and they know what they're buying. But it became very different the larger the disparity between what the government pays under traditional Medicare and the floor county. Then it became a very serious issue.

MS. ROSENBLATT: If we could just capture a little bit of the flavor of what you just said because -- even though we're focused on rural, so we're focused on the floor. I think that the text is just losing a little bit of that overall.

DR. WILENSKY: I agree. I think we ought not to damn the concept as much as the issues that, because of a series of changes that have occurred, have made the potential cost of the program much greater. Again, I personally regarded it as an okay option to have available to choose.

DR. REISCHAUER: If a private entity can provide a Medicare-like service which is open to all eligible people on a regular basis more efficiently than Medicare can, because it's administrative system is better, because it pays certain kinds of providers -- it doesn't overpay certain kinds of providers, great. I say we should encourage that.

DR. WILENSKY: It's really the floor issue that made this a problem.

DR. ROWE: But last year when I was sitting there and you were sitting here you said this was a license to steal.

DR. REISCHAUER: Because of the floor.

DR. WILENSKY: It's the floor. It's not the plan.

DR. REISCHAUER: It's the floor. I'm saying if you can do it more efficiently than Medicare does it in western Nebraska, great.

DR. ROWE: So as an economist though you're faced with the fact that it's a license to steal because of the floor but nobody's stealing.

DR. REISCHAUER: Yes. That's an interesting -- makes you want to rethink human nature.

DR. ROWE: Or economic theory.

[Laughter.]

DR. WILENSKY: No, I think you really hit it, which is the distrust.

DR. REISCHAUER: I think Janet put her finger on it which is, if this took off and lots and lots of people joined, Congress would scratch its head and say --

DR. WILENSKY: Say, what have we done?

DR. REISCHAUER: -- why are we spending all this extra money for basically what people can get a lot cheaper?

MR. HACKBARTH: People are uncertain just by selection risk. If you were considering going into this business you'd want to move slowly and not get out in front of yourself.

DR. ROWE: Having been burned before. But I just want the record to show that only an economist, when there is a difference between human nature and economic theory would say that human nature was wrong.

[Laughter.]

DR. NEWHOUSE: Sometimes we say the data are wrong.

MR. HACKBARTH: I think the point that Alice made about the tone and your language is a good suggestion here. Beyond that though, I'm unsure why we're reviewing all of this again. We went through this in March. It would be helpful if you would identify what's different that we need to talk about again.

MR. GLASS: I'd be delighted to. There is no difference. We're just running through this. In fact we can switch to the next slide which is the conclusions, which are also the same. The only thing I wanted to add here was, in this whole discussion we've assumed risk adjustment is possible. You could say, if risk adjustment is delayed, fair payment is denied or something.

But we may want to come up with some kind of interim solution recognizing that in fact risk adjustment may not be practical for HCFA to figure out how to do it, or Congress may never allow it to happen. So we may want to think about, should we consider some interim solution during the time in which risk adjustment doesn't happen, or would there be an interim solution that would make sense if there is no risk adjustment? In the March report and all that we assumed that we want to make payments equal on a risk-adjusted basis. What if you can't?

DR. WILENSKY: Is there a reason that we aren't talking more

about some of the shared risk ideas that we've talked about in the past?

MR. GLASS: We didn't have anything new to say about that today, so I just whipped through that. But yes, that is in the text.

DR. NEWHOUSE: I had three comments on the chapter. One, although we've all, I think appropriately been, at least dour and negative about floors, I think we should say in the chapter the small metropolitan floor may well bring additional benefits in those areas, because there you typically will have competing plans and benefits will pass through.

MR. GLASS: That may be true, but this is a chapter on rural M+C.

DR. NEWHOUSE: But it kind of takes on floors generally. I think it is what the Congress was trying to do, and we've been so negative about floors that we probably ought to say that.

The second point, on page 10 -- I had brought this up last time. I disagree with the analysis there that M+C plans don't go into rural areas because they can't spread the risk. They can spread the risk over all the beneficiaries they insure. There's no law that says they're limited to spread the risk over just that county. I gave you the example that life insurance companies sell plenty of life insurance policies to people in rural counties and they think they're spreading the risk over everybody they sell a life insurance policy to.

MR. GLASS: Yes, I brought up a little later in regard to that point that spreading over more counties though increases

their network formation problem.

DR. NEWHOUSE: But that's not a risk issue. That's a cost of doing business in the area. I guess my reaction to that is, there's probably a fix cost per provider you contract with, and they're contracting with fewer providers out there too than in metro areas. So I'm not sure that whole line of argument is very convincing.

I think you should rest your hat on the structural problems: that it's very hard to get discounts, and it's hard to enforce compliance because you don't have any leverage with so few providers.

My final comment was on the split capitation option, which I think there's another problem with that that you don't bring up, which is that there's an incentive for the group practice, whoever is getting the risk payment, to unbundle and, for example, shift services to the outpatient department, which we wouldn't want to see happen.

MS. ROSENBLATT: I just had one other comment. I'm not that familiar with cost HMOs and there's a section on cost HMOs. I just thought those were mostly staff model, that there was something about them that caused it to be more attractive to staff model HMOs than to other. Again, I'm talking about of close to total ignorance about the cost HMOs.

MR. GLASS: I'm not sure what the split is.

DR. HARRISON: Most of the ones I'm aware of are staff model, but -- for instance, Kaiser would have --

MS. ROSENBLATT: There's something in the way the

reimbursement works that would make it unattractive if you're not a staff model.

DR. HARRISON: It's because what you're doing is you're providing benefits to the beneficiary, and if the beneficiary uses your network then they get the benefits of lower cost sharing. If they go out of network it's regular Medicare. So if you don't have a network and you're not providing something additional for the beneficiary, there's not much interest by the beneficiary.

They are scheduled to end, I believe in 2004. And some places like Kaiser has both the cost and Medicare+Choice in some areas but the cost plan has closed.

DR. NEWHOUSE: Any other comments on this chapter?

DR. REISCHAUER: There's this little example which came up in an earlier chapter too and I thought I beat it down, but maybe not. This is the sort of, gosh, in some of these areas with the floor we'd end up paying the private fee-for-service plan more than it would cost to buy a Medigap policy. You make it sound like Medicare would save money by making this option available. And of course, everybody would take this option if it were available.

You ought to make sure that some bright-eyed, bushy-tailed staff member of Congress doesn't look at this and say, great idea, let's go ahead with this one. Then we'll have CBO score it as a savings.

MR. GLASS: I thought we said that having Medicare buy Medigap coverage would clearly not be an appropriate solution or

good public policy.

DR. ROWE: But you don't say why. Actually as I recall, you go to the point of saying, you can Medigap C. You actually say which Medigap you can buy. And then you say, but of course we wouldn't want to do that. I think that people might say, wait a minute, maybe we would want to do that. So you might want to put some more stuff in there. I think Bob is right, because of the specificity of going to C and -- it's too concrete for them. I'd say it's too attractive.

MS. NEWPORT: I have a comment on the cost contracts too, so I'll try to wander my way through. I think you have to put some construction around a couple of thoughts in the paper in a historical context.

For example, private fee-for-service came in in BBA, purposefully or not, as BBRA and BIPA came along with working on the floor. They may now be perceived to be the unintended beneficiary of something that probably wasn't part of the matrix or thought process in the first place. I think that that sort of has happened that way. But I think that recognizing the concerns and the consistency with our earlier report, I don't have a problem with that, but I think you need to amplify a little bit on those areas just to give the accurate point in time that some of these things happened.

I think on the cost contract issue, cost contracts that are still out there came about in the '70s. I think they are primarily staff model, urban-based, because that was the only way plans could participate in cost contracting at that point.

That's the only way you could get into Medicare. So these are artifacts that I think have worked in a certain way because there was an age-in effect. Not a lot of explicit, direct marketing. People aged into it from employer, under-65 market accounts. So therefore, the costs were much easier to work with.

I think that that speaks to me to something on the partial risk idea, is that one of the reasons to me that doesn't necessarily work from an operational standpoint is that it doesn't seem to me there would be any diminished regulatory overlay. There may be an additional regulatory overlay. So I think I would caution, put some framework around that. That I'm not sure that that would work.

I think the issue of the large employers that you raise on page 6 -- and I don't mean to say it's an issue -- is up until BIPA there was regulatory constraints on a higher market penetration in the employer accounts. One of the good things out of BIPA was that some of that -- there was authority given to HCFA to loosen up some of their regulatory -- I don't know, there were just some barriers to having more flexibility and creating employer-retiree programs in Medicare.

So the emphasis in the chapter, to me would lead people to the conclusion that somehow this is something that's been clicking along and working very well up till now. I think it's too soon to come to that conclusion. And HCFA actually convened a serious three-day meeting last year on this issue and part of the result of that meeting was some changes in BIPA. So I would back off that just a little bit.

Then I think part of the chapter also talks about the confluence of interests that came together in, I guess it was BBA, that started to address the payment issues in rural areas. It wasn't just that rural areas wanted the better benefits.

I think there were other influences in place, including in urban markets like Minnesota where the initial penetration in the marketplace on Medicare+Choice TEFRA contracts at that point, they were so successful, the moderating impact on fee-for-service payments in the area upon which their payment was based, the lines in the curves crossed and they were now getting payment decreases instead of increases. I think the solution to that is rebasing the payment system that came out in BBA.

I think we should reflect that a little bit and not just make it sound like it was only because we wanted to put more benefits in the rural areas. I think that was part of it. But I think more importantly, the push was to rebase certain urban area payments so that we were bringing them up to what the fee-for-service cost scale was.

So I just think those are constructs around this that make it a little more accurate, and paint a little more refined or a rigorous picture about what happened.

MR. GLASS: We're just very focused on the rural, but we can add the other to the context.

MS. NEWPORT: I think that's right, but I think there were a lot of other things that, if we had known then what we know now I think the pile-on -- in some ways a good way -- all the other subsequent legislation has led to some things that -- I just

think you need to fine-tune that.

DR. WILENSKY: Any further comments?

Thank you.